**Office of the Patient Advocate (OPA)**
**California Health Care Quality HMO and PPO Report Cards, 2015-16 Edition**

**Scoring Documentation for Public Reporting on CAHPS***
**(Reporting Year 2015)**

## Background

Representing the interests of health plan members, the California Office of the Patient Advocate (OPA) publicly reports on health care quality. OPA published its first HMO Health Care Quality Report Card in 2001 and has since annually updated, enhanced and expanded the Report Cards on HMOs, PPOs and Medical Groups. The current version (2015-16 Edition) of the online Health Care Quality Report Cards is available at: www.opa.ca.gov and via mobile apps.

Performance results are reported at a health plan reporting unit level in the HMO and PPO Report Cards. Ten (10) participating health plans report HMO Consumer Assessment of Healthcare Providers and Systems (CAHPS®[1]) results.

Aetna Health of California, Inc.
Anthem Blue Cross of California
Blue Shield of California
CIGNA HealthCare of California, Inc.
Health Net of California, Inc.
Kaiser Foundation Health Plan of Northern California, Inc.
Kaiser Foundation Health Plan of Southern California, Inc.
Sharp Health Plan
United Healthcare of California, Inc.
Western Health Advantage

Six (6) participating health plans report PPO Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results.

Aetna Health of California, Inc.
Anthem Blue Cross of California
Blue Shield of California
CIGNA HealthCare of California, Inc.
Health Net of California, Inc.
United Healthcare Insurance Co., Inc.

**Sources of Data for California Health Care Quality Report Cards**

The 2015-16 Edition of the Report Cards is published in October 2015, using data reported in Reporting Year (RY) 2015 for performance in Measurement Year (MY) 2014. Data sources are:

* Also see the Scoring Methodology for the HMO and PPO Report Cards HEDIS clinical care ratings: http://www.opa.ca.gov/Pages/AboutRatingsandMore.aspx

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS is a source for data contained in the California Health Care Quality Report Cards obtained from Quality Compass®2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA.

1. **The National Committee for Quality Assurance's (NCQA) publicly reported Consumer Assessment of Healthcare Providers and Systems (CAHPS) commercial measure data** and HMO and PPO Healthcare Effectiveness Data and Information Set (HEDIS)**.** (HEDIS Methodology Description in a separate document)
2. The Integrated Healthcare Association (IHA) Pay for Performance Initiative's medical group clinical performance data. (Methodology Description in a separate document)
3. The California Healthcare Performance Information System, Inc. (CHPI) Patient Assessment Survey's (PAS) patient experience data for medical groups. (Methodology Description in a separate document)

## HMO and PPO CAHPS Methodology Process

### 1. Methodology Decision Making Process

OPA conducts a multi-stakeholder process to determine the scoring methodology. Beginning with the 2013 Edition of the Report Cards, OPA enhanced its partnership with IHA's Pay for Performance Initiative. IHA's Technical Measurement Committee (TMC) now serves as the primary advisory body to OPA regarding methodologies for the HMO and PPO Report Cards for both HEDIS clinical and CAHPS patient experience data and the Medical Group Report Card clinical data. Comprised of representatives from health plans, medical groups and health care purchaser organizations, TMC members are well-versed in issues of health care quality and patient experience measurement, data collection and public reporting. OPA's Health Care Quality Report Cards are a standing item at the TMC meetings.

**TMC Roster (2015)**

**Chair:** Mike Weiss, DO: *CHOC Health Alliance*
Marnie Bakier, MD: *MemorialCare Medical Group*
Christine Castano, MD: *Healthcare Partners*
Cheryl Damberg, PhD: *RAND*
Ellen Fagan: *Cigna Healthcare of California*
John Ford, MD: *Family Practice Physician*
Peggy Haines: *Health Net*
Jennifer Hobart: *Blue Shield of California*
Chris Jioras: *Humboldt-Del Norte IPA*
Ranyan Lu, PhD: *UnitedHealthcare*
Leticia Schumann: *Anthem Blue Cross*
Kristy Thornton: *Pacific Business Group on Health*
Ralph Vogel, PhD: *SoCal Permanente Medical Group, or*
Charlotte Yates: *The Permanente Medical Group*

Please note that the methodology and display decisions made by OPA do not necessarily reflect the views of each organization on the advisory committee.

OPA also contracts with Dr. Patrick Romano, who is a national expert in health care quality and public reporting, and a practicing physician and professor at the University of California, Davis Medical School.

Additionally, OPA values the opinions and perspectives of other stakeholders with interest and expertise in the field of healthcare quality measurement, data collection and display and, as such, began conducting annual Stakeholder Briefings in 2013.

2. **Stakeholder Preview and Corrections Period**
   Each year, prior to the public release of the OPA Report Cards, all participating health plans and medical groups are invited to preview the Health Care Quality Report Cards. Health plans and medical groups are given access to a test web site with updated results and given several days to review their data and submit corrections and questions regarding the data and methodology to OPA and its contractors. If an error in the data is discovered, it is corrected prior to the public release of the OPA Report Cards.

## HMO and PPO CAHPS Scoring Methodology

There are three levels of measurement:

1. **Summary Performance**: There are three composite summary performance indicators.

2. **Topic:** There are seven composite topic areas that are reported as single measures.

3. **Stand Alone CAHPS Measures:** The six eligible measures consist of the CAHPS* 5.0H commercial measures for Reporting Year 2015, reported by the National Committee for Quality Assurance (NCQA).

See Appendix A for mapping of CAHPS measures to summary performance indicators and topics.

**Performance Grading**

HMOs and PPOs are graded on performance relative to the nation for CAHPS for "Patients Rate Their Experience" for HMO/PPOs. All of the performance results are expressed such that a higher score means better performance. Based on relative performance, plans are assigned star ratings for multi-level summary indicators.

Star rating performance grading is based on the NCQA RY 2014 Quality Compass® All Lines of Business (Health Maintenance Organization-HMO, Point of Service-POS and Preferred Provider Organization-PPO) benchmarks. Quality Compass RY 2015 values are used to set performance cutpoints for new or revised measures.

1. **Summary Performance Indicator Scoring**
   Three summary performance indicator results are reported: 1) Patients Rate Their HMO/PPO ("Rate Their HMO/PPO") 2) "Getting Care Easily" for HMO/PPO and 3) "HMO/PPO Helps Members Get Answers".

   a) The "Rate Their HMO/PPO" rating (Q. 42) item is reported as an overall summary rating. The Overall Rating is scored as the proportion of respondents reporting a 9 or 10 on a 0-10 scale.

b) The "Getting Care Easily" indicator is an aggregation of two composites: 1) "Getting Doctors and Care Easily" and 2) "Getting Appointments and Care Quickly". This rating is used for HMOs and PPOs.

c) The respondents included in the "HMO/PPO Helps Members Get Answers" indicator are members of the survey sample who contacted their plan. The "HMO/PPO Helps Members Get Answers" indicator is an aggregation of three composites: 1) "Plan Customer Service", 2) "Paying Claims" and 3) "Plan Information on What You Pay". This rating is used for HMOs and PPOs.

d) Refer to HEDIS® 2015 Volume 3: Specifications for Survey Measures for a detailed description of the composite results scoring method.

e) The summary indicator, "HMO/PPO Helps Members Get Answers," is scored using a two-step method:

   i. **In Step 1,** the proportional rate is calculated for each question included in the summary indicator. The proportional rate is a two-year rolling average for RY 2015. The MY 2013 and MY 2014 numerators and denominators are summed to calculate the rate.

      - The minimum denominator standard is applied at the summary indicator level – a plan must have an aggregate minimum of 100 respondents when summing the question denominators for that summary indicator.

   ii. **In Step 2,** the proportional rates are summed for all of the relevant questions and divided by the number of questions to yield an overall rate.

      - Each question rate is equally weighted.

      - Results are rounded to the tenths value – this summary indicator score is used to assign the performance grade per the instructions below. The questions that comprise the summary indicators are listed in Appendix A.

**2. Composite Topic Scoring**

The NCQA CAHPS proportional scoring specifications are used to score the composites and items in Appendix A. Per NCQA scoring rules, CAHPS composite and item results are rounded using the tenths value as calculated in the raw proportional rate (e.g., a value of 79.4999 is rounded down to 79 and a value of 79.5111 is rounded up to 80).

**3. Handling Missing Data**

Not all health plans are able to report valid rates for all measures. In order to calculate summary performance indicator star ratings for as many health plans as possible, we impute missing data under specific conditions using an adjusted half-scale rule. This is accomplished by developing an actual measure level result for plans with missing data, and using those for star calculations. Imputed results are not reported as an individual rate. If a plan is able to report valid rates for at least half of its measures in a topic, then missing values will be replaced using this adjusted half-scale rule for all measures in the topic. Because eligibility for missing value re-assignment

(imputation) is assessed independently at the summary indicator level, it is possible to have a summary indicator score even if topic scores are missing.

**4. Changes from the 2014-15 Edition Report Card to the 2015-16 Edition Report Card.**

a) For Patients Rate Their Experience Star Ratings, patient responses were included in the calculation if the score was a 9 or 10 for the following measures; responses were previously included if the score was an 8, 9 or 10:
   - ”Members Rate Their HMO”/Health Plan Highly Rated
   - Health Care Highly Rated

b) For Patients Rate Their Experience Star Ratings, the CAHPS measure “Members Rate Their PPO” single question was added to the PPO Report Card as a Star Rating along with the stand alone measure. Patient responses were included in the calculation if the score was a 9 or 10.

c) The “Members Rate Their HMO” measure was added to the HMO Report Card as a measure rating, along with the star rating. Patient responses were included in the calculation if the score was a 9 or 10.

**5. 2015-16 Edition Report Card Notes**

a) An individual plan result will not be reported for an individual composite or item if the NCQA CAHPS standard of requiring a minimum 100 respondents per question is not achieved. For these missing scores the phrase, “Too few members in sample to report” is displayed.

b) Measures will be dropped from star rating calculations and benchmarks if at least 50% of California plans cannot report a valid rate. Rates will be reported for all plans with valid rates, regardless of whether a particular measure has been dropped from a star rating calculation due to less than 50% of California plans having a valid rate.

c) The following measures are a two-year rolling average. The responses for the numerator across two years are summed and divided by the responses for the denominator across two years to create a two-year rolling average.
   - “Plan Customer Service”
   - “Paying Claims”
   - “Plan Information on What You Pay”

**6. Calculate Percentiles**

a) One of four grades is assigned to each of the three summary performance indicators using Table 1 cutpoints. Three cutpoints are used to calculate the performance grades. Cutpoints were calculated per the MY 2013 (RY 2014) NCQA Quality Compass nationwide results for all plans (Health Maintenance Organizations-HMO, Point of Service-POS and Preferred Provider Organizations-PPO).

b) The cutpoints are calculated by summing the nationwide scores for the respective percentile value for each measure in a given summary indicator. In turn, the measure-specific percentile scores are summed and an average score is calculated for each of the three cutpoints for that summary performance indicator.

**7. From Percentiles to Stars**

a) Health plan performance in MY 2014 is graded against score thresholds derived from MY 2013 (RY 2014) data. There are three thresholds corresponding to four-star rating assignments. If a summary performance indicator composite rate meets or exceeds the "Excellent" threshold, the plan is assigned a rating of four stars. If a summary performance indicator composite rate meets or exceeds the "Good" threshold (but is less than the "Excellent" threshold) then the plan is given a rating of three stars. If a summary performance indicator composite rate meets or exceeds the "Fair" threshold (but is less than the "Good" threshold) then the plan is given a rating of two stars. Summary performance indicator scores that are less than the two star "Fair" threshold result in a rating of one star "Poor".

b) The grade spans vary for each of the three summary performance indicator topics listed in Table 1:

Top cutpoint: 90$^{th}$ percentile nationwide
Middle cutpoint: 50$^{th}$ percentile nationwide
Low cutpoint: 25$^{th}$ percentile nationwide

**Table 1. HMO and PPO CAHPS Performance Cutpoints for Grade Assignment 2015-16 Edition Report Card**

| *Topic* | *Number of Measures Included* | *Excellent Cutpoint* | *Good Cutpoint* | *Fair Cutpoint* | *Poor Cutpoint* |
|---|---|---|---|---|---|
| HMO/PPO Helps Members Get Answers | 3 | 86 | 79 | 76 | <76 |
| Getting Care Easily | 2 | 91 | 88 | 85 | <85 |
| Rate Their HMO/PPO | 1 | 58 | 38 | 32 | <32 |

c) A buffer zone of a half-point (0.5) span is applied. Any HMO or PPO whose score is in the buffer zone that is 0.5 point below the grade cutpoint is assigned the next highest category grade. For example, an "HMO/PPO Helps Members Get Answers" score of 75.5 would be assigned a grade of Fair. A score of 75.4, which is outside of the buffer zone, would be assigned a grade of "Poor".

## Appendix A

## Mapping of CAHPS Measures to Performance Summary Indicators

| Summary Performance Indicator | Composite or Topic | Definition | Question # | Reported as Stand Alone Measure |
|---|---|---|---|---|
| Getting Care Easily | Getting Doctors and Care Easily | In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed? (never-always) | 25 | ✓ |
| | | In the last 12 months, how often was it easy to get the care, tests, or treatment you needed? (never-always) | 14 | |
| | Getting Appointments and Care Quickly | In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed? (never-always) | 4 | ✓ |
| | | In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? (never-always) | 6 | |
| HMO/PPO Helps Members Get Answers | Plan Customer Service | In the last 12 months, how often did your health plan's customer service give you the information or help you needed? (never-always) | 35 | ✓ |
| | | In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect? (never-always) | 36 | |
| | Plan Information on What You Pay | In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment? (never-always) | 31 | ✓ |
| | | In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines? (never-always) | 33 | |
| | Paying Claims | In the last 12 months, how often did your health plan handle your claims quickly? (never-always) | 40 | ✓ |
| | | In the last 12 months, how often did your health plan handle your claims correctly? (never – always) | 41 | |
| Rate Their HMO/PPO | Global Plan/ Health Plan Highly Rated | Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan? (0-10) (also reported as a alone measure for HMO and PPO) | 42 | ✓ |

## Appendix A

## Mapping of CAHPS Measures to Performance Topics

| Stand Alone Measures | Composite or Topic | Definition | Question # | Reported as Stand Alone Measure |
|---|---|---|---|---|
| | Doctor Communication | In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand? (never-always) | 17 | ✓ |
| | | In the last 12 months, how often did your personal doctor listen carefully to you? (never-always) | 18 | |
| | | In the last 12 months, how often did your personal doctor show respect for what you had to say? (never-always) | 19 | |
| | | In the last 12 months, how often did your personal doctor spend enough time with you? (never-always) | 20 | |
| | Shared Decision Making | When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want to take a medicine? | 10 | ✓ |
| | | When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might not want to take a medicine? | 11 | |
| | | When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you? | 12 | |
| | Health Care Highly Rated | Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months? (0-10)? | 13 | ✓ |
| | Coordinated Care | In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers? | 22 | ✓ |
| | Health Promotion | In the last 12 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness? | 8 | ✓ |
| | Answer Customer Phone Calls Quickly* | The percentage of calls received by the organization's Member Services call centers (during operating hours) during the measurement year that were answered by a live voice within 30 seconds. | CAT | ✓ |

*Note that the *Answer Customer Phone Calls Quickly* measure is a HEDIS measure used to evaluate patients' access and availability of care, and is not part of the CAHPS survey. OPA reports this measure with the Patient Experience measures because it relates to patient experience and may help consumers make health care decisions.